Notice

This form is processed for payment with an electronic reader. Some local printers and copiers do not produce exact copies of the form. If you have a submission returned because **"Margins not Aligned Properly - Does Not Match Original Claim Form"**, you will need to order paper copies of the form and resubmit your claim.

Forms may be ordered from Commonwealth Martin by phone at (804) 780-0076. There is **no charge** for the forms or shipping and handling.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE ADJUSTMENT/VOID INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT ☐ 092	VOID ☐ 094	2 BILLING PROVIDER NUMBER	A ICN/REFERENCE NUMBER	B REASON	C INPUT CODE
3 RECIPIENT'S LAST NAME	FIRST NAME	4 RECIPIENT'S I.D. NUMBER (12)	5 PATIENT ACCOUNT NUMBER	6 RENDERING PROVIDER NUMBER	

7 PRIMARY CARRIER INFO OTHER THAN MEDICARE	8 TYPE COV. MEDICARE	9 DIAGNOSIS	10 PLACE OF TREAT.	11 ACCIDENT/EMER. INDICATOR	12 TYPE SERV.	13 PROCEDURE CODE (5)	14 VISITS/UNITS STUDIES (3)	15 DATE OF ADMISSION	16 STATEMENT COVERS PERIOD FROM THRU
☐ 2 NO OTHER COV. ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COV.	☐ B			☐ ACC ☐ EMER ☐ OTHER				MO. (2) DAY. (2) YEAR (2)	MO. (2) DAY. (2) YEAR (2) MO. (2) DAY. (2) YEAR (2)

17 CHARGES TO MEDICARE	18 ALLOWED BY MEDICARE	19 PAID BY MEDICARE	20 DEDUCTIBLE	21 COINSURANCE	22 PAID BY CARRIER OTHER THAN MEDICARE	23 PATIENT PAY AMOUNT LTC ONLY

24 NDC	

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

INSTRUCTIONS FOR COMPLETION OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS - 31

PURPOSE: To provide a means of making corrections or changes in claims that have been approved for payment. This form cannot be used for a follow-up of denied or pended claims.

EXPLANATION: To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1: Adjustment / Void - Check the appropriate block.

Block 2: Billing Provider Number - Enter the billing provider identification number used by Medicaid. Also, enter the provider's name and address if not printed on the form.

Block 2 A: ICN/Reference Number - Enter the ICN/reference number, indicated on the remittance voucher, of the claim to be adjusted or voided. The adjustment or void can not be processed without this number.

Block 2 B: Reason - Leave blank

Block 2 C: Input Code - leave blank

Block 3 - 24: Please refer to DMAS - 30 for the completion of these blocks.

Remarks: This section of the invoice should be used to give a brief explanation of the change needed.

Signature: Signature of the provider or agent and the date signed are required.

Mechanics and Disposition:

The form may either be typed or legibly handwritten.